1. Bureaucracy and scheduling collided in January to teach a crass lesson on inefficiency. Medical Standards, SEMAC and the other various SEMSCO Committees met, deliberated and collaborated to bring numerous motions forward to SEMSCO, scheduled as the final meeting of the two-day marathon. It was not to be however, for lack of a quorum. Numerous members await vetting through hugely inefficient NYS government processes, others were absent to attend the NAEMSP (National Association of EMS Physicians) meetings in San Diego (scheduled some 4 year prior to SEMSCO, but nonetheless overlapping). Alternates present in place of absent members have no voting privileges. All business is relegated to the May 2018 SEMSCO meeting. Probably equally embarrassing, following the retirement of Bureau Director Lee Burns, Director Mark Hennessey of the Center for Healthcare Provider Services and Oversight was in attendance, probably to explain how DOH plans to maintain the continuity of the Bureau. Oh well…
2. Fear not that these notes would be without fodder, as neither rain nor snow nor sleet nor lack of a quorum prevent reporting on the deliberations leading up to the ill-fated SEMSCO non-meeting. First, a review of the long list of items previously deferred to this January meeting. The proposal to move manual defibrillation from Paramedic to the AEMT level was withdrawn. The BLS protocol workgroup, overwhelmed by a last minute treasure trove of proposed changes and comments from the EMSC folks (far exceeding a mere review of pediatric implications), had their planned unveiling of a BLS protocol set totally derailed. Stroke protocols sunk further into limbo following a presentation from the DOH stroke gurus. And, the appeals committee reviewing the Nassau REMAC suspension of ALS Services, Inc. actually submitted recommendations to SEMAC that would have gone to SEMSCO had there been a SEMSCO meeting (although, if you read Public Health Law, this step may not actually be necessary). Read on for the gruesome details.
3. Medical Standards met to tackle complex protocol questions such as whether tooth reimplantation should be deleted from the BLS protocol set. This surprisingly difficult debate included discussion on average number of teeth between regions (hah). After chewing on it, the vote was to keep it in the protocols, which this writer considers a win-win as coffee creamers now have a rightful place in each ambulance. Far more lively debate sought to answer the ephemeral (that's long-standing, for you vocabulary challenged folk) question of what defines a pediatric patient. The proposed BLS protocol definition of a child is, "under 12 years old or less than 30 kg (66 pounds)." No one liked that. Peds docs argued (incorrectly) that the American Academy of Pediatrics define a child as less than 21 years old and the trauma folks typically use less than 15. In reality, AAP defines a child as less than 20. The AHA says that signs of puberty delineate a child from an adult, something it does not seem wise to ask EMS providers to check for (if you know what I mean). Long story short, it was decided to use the age of 15 as the cut off between child and adult (i.e., when you hit your 15th birthday, you are an adult for the purposes of NYS protocols). Of course, neither the teeth nor the age 15 thing will become official until they are approved by SEMSCO (maybe in May).
4. Stroke center designation was the focus of a Med Standards presentation by the DOH Quality and Patient Safety people. The voluntary DOH stroke center designation program, launched in 2004, has thus far designated 120 hospitals as stroke centers. The quality metrics, reporting and performance measures are also voluntary, have not kept up

with evolving evidence based stroke guidelines and are largely insufficient to ensure program integrity. Of the 120 centers designated, zero (yup, zippo) have been "undesignated". DOH proposes, and is seeking regulation to designate stroke centers based on outside agency review, require submission of comprehensive data and participation in quality initiatives, and establish a process for withdrawing stroke center designation. Designation would likely certify both primary and comprehensive stroke centers (a major EMS conundrum at present) and, if incorporated into NYS Regulations, provide a 2-year transition period for currently designated stroke centers to be re-designated. This sounds incredibly promising – stay tuned…

5. Lee Burns has actually retired as State EMS Director. Andy Johnson is now the acting Bureau Director and he expected DOH to name a permanent EMS Director before the end of January 2018. Make the February, maybe…
6. Training and Education learned that the reg change to lower the age of eligibility for EMT certification to 17 has yet to be published in the State Register for public comment. This actually happened January 24th, which closes the public comment period March 26th. The proposed regulations and public comment site are at https://govt.westlaw.com/nyreg/Document/I0083ce5100ec11e8a6bd94d66ce6e2b0?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=%28sc.Default%29.
7. The current Epi-Pen policy statement (#17-06) has led some to believe that pharmacists can prescribe epinephrine auto-injectors. They cannot. The policy will be updated to eliminate this confusion. Duh oh.
8. On 11/21/2018, DOH released their NEMSIS 3.4.0 Data Dictionary supplement. This allows PCR vendors to begin updating their software for NEMSIS 3 compliance. Image Trend, the Bureau's PCR bridge contractor, is still building a bridge to allow NYS to receive NEMSIS 3 data with an expected completion date of March 2018. No need to delay implementing NEMSIS 3 at the local level; DOH will receive all previous data submitted in version 3 format once they go live.
9. On the subject of PCRs, a new form (DOH-5136), Approval for Agency Use of ePCRs, is available on the web site (www.health.ny.gov/professionals/ems/emsforms.htm) and will be sent to each service with their CON renewal paperwork. Take this as a "hint" from DOH that if you're not using ePCRs, you should be. Like other writing on the wall, it is gonna be a requirement someday. Just sayin'
10. PAD (Public Access Defib) Notices of Intent (NOIs) need to be resubmitted to the Bureau when there is a change in the Emergency Health Care Provider (EHCP) or Service Medical Director (SMD). Third party vendors need to obtain a signature on NOIs from a responsible party at the PAD entity. SMDs also need to be currently licensed NYS physicians. Read this item again if you didn't follow all the abbreviations the first time.
11. MOLST is going electronic! eMOLST is now live at www.compassionandsupport.org. The Bureau plans a roll out of eMOLST to EMS services later this year.
12. SHIN-NY is a "network of networks" connecting the eight regional healthcare electronic exchanges (RHIOs). Each exchange connects physicians, hospitals, labs, nursing homes, and other health care providers (but not EMS) to allow patient record and data sharing. With the roll out of SHIN-NY, monies are expected to become available to connect EMS into the mix. Stay tuned…

13. FirstNet, the nationwide dedicated broadband public safety network saw all 50 states, two territories and the District of Columbia join. The network, contracted to AT&T, has begun buildout and EMS agencies are likely to hear from AT&T about it soon (if not already). If you don't know what FirstNet is, you've got problems (i.e., better Google it).
14. Is Uber replacing you? Indeed it is, say two University of Kansas researchers who examined ambulance usage trends before and after Uber launched in 700 cities. Their most conservative estimate of ambulance business lost to Uber is 7% and they theorize EMS transports lost to Uber will stabilize at 10 to 15% as Uber continues to expand. The study has been submitted for publication in a peer reviewed medical journal. In the meantime, these guys are garnering hype in the mainstream media any way they can: www.citylab.com/transportation/2017/12/the-new-uber-for-ambulances-isuber/548825/.
15. Following the previously reported meeting between SEMAC/SEMSCO docs and the NYS Health Commissioner, the Governor called out a need to strengthen rural EMS in his State of the State address. His three pronged proposal to strengthen rural EMS includes:
    1. A digital and media campaign highlighting careers in EMS and legislation that would facilitate community paramedicine.
    2. Expansion of EMS training program into more diverse and non-traditional settings, working closely with BOCES and community colleges.
    3. In depth management training for EMS administrators.

    If you've got nothing better to do than poke your eyes out, you can download the speech at www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/2018-stateofthestatebook.pdf - the part about EMS begins on page 254. Kudos to the Gov for finally taking notice of EMS!
16. The CME program is set for a revamp! Hopefully, revised materials will release May 1. Changes are designed to align with the National Registry's NCCP (National Continued Competency Program) – see www.nremt.org/rwd/public/document/nccp as well as National EMS Educational Standards. Required hours will most likely match the NCCP so don't get your panties all in a bunch – that means LESS than currently needed.
17. Instructor exam scores continue to improve. To date, 359 candidates have taken the CLI exam with 93% passing on the first attempt, 5% on the second, 2% on the third and 1% on the fourth attempt. 508 have taken the CIC exam with 64% passing on the first attempt, 12% on the second attempt, 6% on the third, 1% on the fourth, and one person on the 5th. Yes, you did the math correctly, 17% of CICs are still out there somewhere. While nerve wracking, I finally took the CIC test myself and ended up in the 64% first time pass group as did my friend and colleague Howard Huth from SUNY Cobleskill. Phew!
18. T&E was updated on the CCT bridge program. Northwell Health is developing an on-line bridge and presently finishing a gap analysis to guide content. The product should be available around May 1. It also appears that sponsors will be able to obtain reimbursement through current course funding streams for CCT to Paramedic bridge courses. A whole lot more detail will be out once program development wraps up.
19. The CIC/CLI recertification form on the Bureau web site has been updated, increasing the required CME hours from six to eight with only three needing to come from a CIU (Certified Instructor Update course). The five remaining hours can come from any educational methodology training class/course/session. An accompanying revision to the policy statement should post to the Bureau site once it clears whomever at DOH approves

it for posting. The form and policy statement revision were submitted together but in true NYS DOH style, seem to have been separated at birth.

20. EMSC (EMS for Children) reported new deliverables accompanying their federal grant funding. Having previously been directed to survey EMS agencies about pediatric equipment carried, they are now being told to survey for and encourage provider training on pediatric equipment use at the agency level minimally biennially. They also will encourage each EMS service to appoint a pediatric emergency care coordinator, which, on the hospital side of the house, has facilitated compliance with training.
21. SEMAC voted to approve Mercy Flight protocols. The also voted to accept the recommendation from an appeals committee on the ALS Services, Inc. appeal of their suspension by the Nassau REMSCO. The appeals committee recommended lifting the suspension if the appellant submits quality improvement data by 2/10/2018 for transports that initiate or terminate in the Nassau region. This was not a brief discussion. Of note, no one from ALS Services (a subsidiary of Hatzolah) came to the meeting. Kinda makes you think, "Hmmmmm." As mentioned earlier, it is unclear if this decision needs to go to SEMSCO for a vote. It may not.
22. The Finance Committee, in their annual exercise in futility, approved a 2018/2019 recommended budget for EMS in NYS of $24.2 million. This includes a 10% increase to Program Agency Budgets (last increased 21 years ago). Since SEMSCO had no quorum, the budget will wait until May. No foul – the Legislature has not seemed to care about it for the past 21 years. Why change?
23. In case you have been asleep at the wheel, the EMS Fatigue folks released results of their research and recommendations every EMS agency should implement. See www.nasemso.org/Projects/Fatigue-in-EMS/index.asp for the low down.
24. WISER, the Wireless Information System for Emergency Responders, released Version 5.1, updating their apps and software (which run on any device you happen to carry or park on your desk). WISER is a collection of hazardous materials resources and tools consolidated into a single neat package. See: https://wiser.nlm.nih.gov/index.html.
25. The Food and Drug Administration launched a public dashboard for their adverse events reporting system, a widely used system for reporting adverse events, medication errors and product quality concerns about drugs and drug products. Reports are submitted by manufacturers, consumers and healthcare professionals and, until now, have only been available by filing a Freedom of Information request. For information on the searchable database for adverse drug reports or to give your parents something to do, see: www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Surveillance/AdverseDrugEffects/ucm070093.htm
26. In a totally predictable move, DOH downgraded the few remaining ALS services that failed to comply with a July 2016 update to Part 800.5 requiring all ALS services to obtain a Controlled Substances License so they could, at minimum, carry meds needed to stop a seizure and treat patients with severe pain. Most of the agencies were in Nassau County where, according to this news article, they rarely see seizure patients or people with pain: www.liherald.com/rockvillecentre/stories/rvc-fire-department-18-other-ems-agencies-downgraded,99537. It also must be much hotter in Nassau than anywhere else in NYS given their apparently unique need for refrigerators. Makes you go, "hmmmmm"
27. Did you know that CPR and ACLS Guidelines are no longer being updated on 5-year cycles? Updates are now, "Annual Focused Updates," and while the 2017 updates were

apparently not compelling enough to revise textbooks and instructor materials, you can have a peek at www.resuscitationjournal.com/article/S0300-9572(17)30675-5/fulltext#sec0060. The 2018 updates, due out towards the end of the year, do sound like they'll be meatier.

28. While I rarely highlight political issues here, a recent legislative change supported by the fire service in NYS to amend General Municipal Law 209b allowing fire districts to bill for EMS service has come under unwarranted and heavy attack by volunteer and commercial EMS membership associations as, "removing the ability of rural residents to access ALS intercept services." This is a complete distortion of the truth. Fire Districts in NYS, who provide the ambulance service to 37% of the state's population, are the only ambulance services in the United States prohibited from billing. As a result, many are facing extinction. The real issue is an obscure Federal Law that allows commercial and non-fire volunteer services to bill Medicare directly for ALS intercept services - only when Fire Departments are prohibited from billing. Were FDs permitted to bill, ALS intercepts would need to be billed not by the ALS service but by the FD (as they are in the rest of the US) and payment turned over to the ALS service. The NYS legislative change supported by the Fire Service would allow FD billing and REQUIRE FD's to have an agreement in place with an ALS service to share the reimbursement. This assures rural residents continued access to ALS and, more importantly, assures that their rural volunteer fire departments can continue to respond to life threatening emergencies. Don't believe everything you read on Facebook – no seniors are going to lose a Medicare benefit and no one would lose access to ALS services if this legislation passes. Oddly, folks currently paying fire district taxes in addition to paying for health insurance cannot receive their insurance benefits since their FD ambulance cannot bill. Their taxes would be less were this to change. See the proposed legislation yourself: https://open.nysenate.gov/legislation/bills/2017/s363/amendment/b.
29. SEMSCO will attempt to meet again May 15-16 and September 25-26, 2018 as well as January 15-16, 2019 at the Hilton Garden Inn in Troy. Perhaps the HGI will have found an alternate location for the very large Christmas tree they had adorning the meeting room.

These notes respectfully prepared by Mike McEvoy who currently awaits vetting so he can represent the NYS Association of Fire Chiefs on SEMSCO. He will, if ever vetted, replace Mike Murphy who has served tirelessly for 8 years. Contact Mike at mmcevoy@saratogacountyny.gov or visit www.mikemcevoy.com. If you want a personal copy of these "unofficial" SEMSCO minutes delivered directly to your email account, go to http://eepurl.com/iaXHY to put yourself on the list (or adjust your delivery settings). Also, past copies of NYS EMS News are parked at the bottom of the EMS News page at www.saratogaems.org. Feel free to download any notes you missed. Tell your friends. The more, the merrier.